Medicaid



Montana Medicaid Certificate of Medical Necessity

Durable Medical Equipment (DME) and Supplies (Rev. October 2014)

EPSDT Nutritional Services for Individuals Under Age 21			
Patient Name, Address, Telephone Number, and Date of Birth		Physician Name, Address, and Telephone Number	
Medicaid ID Number		NPI Number	
Diagnosis	Height		Weight
Prognosis		Estimated Length of Need (Months) 1–99 (99=Lifetime)	
		Hyper metabolic Aspiration	☐ Impaired consciousness ☐ Other
2. Residence			
3. How many days per week administered? (1–7)			
4. List product names with the number of calories per day for each product.			
5. Method of administration Syringe Gravity Pump Does not apply			
6. Does the patient have a documented allergy or intolerance to semi-synthetic nutrients?			
7. Narrative description of all items, accessories, options, and special additives ordered to include amounts. If additional space is needed, a continued narrative can be attached to this document as long as the pertinent patient and physician information is included at the top of the attachment. Physician's signature must also be included on the attached document). Yes, additional attachments are included. No, additional attachments are not included.			
I certify that I am the treating physician identified in this form. I certify that the medical necessity information contained in this document and its attachments are true, accurate, and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in this document may subject me to civil or criminal liability.			
Signature and date stamps are not acceptable.			
Physician's Signature		<u></u>	Date (mm/dd/vvvv)